CAH QI Coordinator Webinar

February 18, 2016

Healthcare Intelligence

Agenda

- Welcome - Mary Beth Sorensen
- MBQIP Updates - Mary Beth Sorensen
- IDPH FLEX HIT - Marlene Hodges and Lisa Muggenberg
- Meaningful Use Updates - Sandy Swallow, QIN QIO
- SHIP Updates – Doreen Chamberlin
- Stakeholder Reports - IHC, IHA, DIA, IDPH, QIN-QIO
- Outpatient Quality Improvement Initiative - Barbara Wilke
- Wrap Up - Mary Beth Sorensen

MBQIP Quality Domains – Required

- Patient Safety
  - NHSN – Healthcare Worker Influenza Vaccination – reported on NHSN
  - IMM 2 – Inpatient Influenza Immunization – reported via CART to Quality Net

- Patient Engagement
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) – reported by hospital or vendor to Quality Net

MBQIP Quality Domains Required cont.

- Care Transitions
  - Emergency Department Transfer Communication (EDTC) 45 records max/quarter or 15/month
    - EDTC -1: Administrative Communication – 2
    - EDTC -2: Patient Information – 6
    - EDTC -3: Vital Signs – 6
    - EDTC -4: Medication Information – 3
    - EDTC – 5: Physician or practitioner generated information – 2
    - EDTC -6: Nurse generated information – 6
    - EDTC –7: Procedures and tests – 2
    - All Categories: number of patients meeting all data elements in all categories.
  - Submitted on HEN Database monthly- deadline is noted in HEN Database Toolkit- page 14.

MBQIP Quality Domains Required cont.

- Outpatient
  - AMI/Chest Pain Transfers – reported on CART to Quality Net
    - OP 1: Median Time to Fibrinolysis
    - OP 2: Fibrinolytic Therapy Received within 30 minutes
    - OP 3: Median Time to transfer to another facility for Acute Coronary Intervention
    - OP 5: Median Time to ECG
  - ED Throughput – reported on CART to Quality Net
    - OP 20: Door to diagnostic evaluation by a qualified medical professional
  - ED Throughput – Structural Measure – reported on Quality Net
    - OP 22: Patient Left without being seen CY 2015 data reported between July 1 – November 1 2016
  - Pain Management – reported on CART to Quality Net
    - OP 21: Median Time to pain management for long bone fractures

What does required mean?

- 2015 -2016 is Planning and Implementing year of new grant.
  - Must be able to report one quarter by 3Q 2016 – DON'T WAIT TILL LAST QUARTER!
- Hospitals must participate in required activities of MBQIP to receive money and/or services of FLEX program for next year.
  - Educational opportunities through both FLEX Patient Safety/Quality Improvement and HIT contracts. Includes education, CEUs, and mileage to programs.
  - Travel stipend to attend HEN2 training
  - SHIP grant money
  - Finance and Operations TA/consultation with Stroudwater

MBQIP Quality Domain –Additional Improvement Activities

- Patient Safety
  - CLABSI, CAUTI, CDI, MRSA – reported on NHSN
  - Stroke
  - VTE
  - Perinatal Care – OP -01: Elective Delivery
  - Surgery/Surgical Care – OP 25: Safe Surgery Checklist Use
  - Pneumonia
  - Falls
  - Adverse Drug Events (ADE)
  - Reducing Readmissions
  - AHRQ Patient Safety Culture Survey

MBQIP Quality Domain –Additional Improvement Activities

- Patient Engagement – none
- Care Transitions – potential measures
  - Discharge planning - TBD by FORHP
  - Medication Reconciliation – TBD by FORHP
- ED Throughput
  - ED-1: Median time from ED arrival to ED departure for admitted ED patients
  - ED-2: Admit decision time to ED departure time for admitted patients
  - OP-18: Median time from ED arrival to ED departure for discharged ED patients

Deadlines

- EDTC –
  - January data due in IHC/HEN Database by February 19, 2016
  - February data due – March 18, 2016
  - March data due – April 15, 2016
- 4Q 2015 applications will be available early to mid March – May 2016 deadlines will remain in place
  - CART
  - Hospital Inpt Population & Sampling
  - Hospital Inpt Measure Designation
  - CMS Clinical Warehouse
  - Vendor Authorization

SAVE the DATE

- April 21, 2016: CAH QI Coordinator Meeting
  - Hilton Garden Inn, West Des Moines

- June -July 2016: Regional CAH QI Coordinator Meetings
  - Five Dates and locations TBD

Resources

- MBQIP EDTC Abstraction Guide: http://www.stratishealth.org/providers/ED_Transfer_Resources.html
- National Rural Health Resource Center: http://www.ruralcenter.org
- FLEX Monitoring Team: www.flexmonitoring.org

Contact Information

- Mary Beth Sorensen: 515-273-8806 or msorensen@telligen.com
- Sandy Swallow: 515-223-2105 or sandy.swallow@area-d.hcqis.org
- Marlene Hodges: 515-457-3707 or mhodges@telligen.com
- Barbara Wilke: 515-223-2907 or barbara.wilke@area-d.hcqis.org

FLEX 2016 - 2017

Staff Training and Quality Data Reporting

Focus: Staff Training & Quality Data Reporting

- There are a host of clinical quality data programs all requiring submission of organization/provider data

- Focus of this FLEX CAH program: provide education and training related to understanding the processes, cross-training staff, documenting processes, the importance of submitting data and highlighting impact to healthcare quality and value-based purchasing

Examples of Clinical Quality Data Programs

- Inpatient Quality Reporting (IQR)
- Outpatient Quality Reporting (OQR)
- Meaningful Use (MU)
- Physician Quality Reporting System (PQRS)
- National Healthcare Safety Network (NHSN)
- Medicare Beneficiary Quality Improvement Project (MBQIP)

Education & Technical Assistance

- Gather and share best practices related to collection and submission of clinical quality measures
- Highlight the importance of clinical quality data to improve healthcare quality
- Educate on the importance of staff role in healthcare quality and value based purchasing

Education & Technical Assistance - *Continued*

- Process documentation: are your processes for submitting clinical quality data documented and updated regularly?
- Staff cross-training: are back-up staff members identified and trained?
- Analysis and integration of data reports: how are you using data to drive improvement?

Surveying Iowa CAHs

Survey Monkey emailed to CAHs at end of January to gauge:

- Current understanding of process
- Current understanding of importance of role in healthcare quality and value-based purchasing
- Current training and bench-strength support at organization

Sharing and Working Together

- Partner in Regional Meetings – 5 statewide locations
- Webinar group trainings
- Sharing of best practices and tools
- Site visits

Contact Information

- Marlene Hodges
  - (515) 457-3707
- mhodges@telligen.com

Meaningful Use

Meaningful Use Deadlines

Attestation Deadlines for 2015 program year

- Medicare: **January 4, 2016 - February 29, 2016**
- Iowa Medicaid: **February 1, 2016 - April 1, 2016**

Hardship Application Deadlines

- Eligible Professionals: **March 15, 2016**
- Eligible Hospitals and CAHs: **April 1, 2016**
- Specific CAH application form
- **https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html**

MU Is Being Merged Into MIPS, "Not Dying"

The reports of MU death are greatly exaggerated

"The implementation of the bipartisan MACRA legislation is a major item squarely on our punch list that has everyone's attention. At its most basic level it is a program that brings pay for value into the mainstream through something called the **Merit-based incentive program**, which compels us to measure physicians on four categories: quality, cost, the use of technology, and practice improvement. … At its core, we need to simplify. **We have the opportunity to sunset three old programs and align them together in a single new program.**… The Meaningful Use program as it has existed, will now be effectively over and replaced with something better."

-Andy Slavitt, Acting CMS Administrator

What is the Merit-Based Incentive Payment System?

- Jan. 1, 2019 – MIPS payment adjustment begins and applies for 2019 onward
- Secretary must develop a methodology to assess EP performance and determine a composite performance score
- Combines features of 3 current quality incentive programs into a single program
  - Physician Quality Reporting System (PQRS)
  - Value-Based Modifier (VBM)
  - Meaningful Use (MU)
- Adjustment can be Positive, Negative, or Zero

MIPS and Critical Access Hospitals

Q: How does MIPS work for critical access hospitals (CAHs)? How will it interact with the Schedule II billing?

A: MIPS applies only to EPs and not to facilities like CAHs. Information on how MIPS will affect EPs billing under Method II will be in the proposed rule next year.

Stakeholder Reports

- SHIP- Doreen Chamberlin
- IHC
- IHA– Kathy Trytten
- DIA – Trish Hubbard
- Telligen QIN-QIO
- IDPH FLEX- Jeana Christensen

Outpatient Quality Improvement Initiative

Brady Allen, Student Intern

Barbara Wilke, Improvement Advisor

Program Specialist

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

Overview

- Drake University Senior Capstone Student
- Identify opportunities for improvement in OP measures
- Identify and track a performance improvement project
- Demonstrate improvement
- Move measures towards the baseline median threshold

Target Outpatient Measures

- **OP-1:** Median time to fibrinolysis
- **OP-2:** Fibrinolytic Therapy received within 30 minutes of ED arrival
- **OP-3:** Median time to transfer to another facility for acute coronary intervention
- **OP-4:** Aspirin at arrival
- **OP-5:** Median time to ECG
- **OP-18:** Median time from ED arrival to ED departure for discharged ED patients
- **OP-20:** Door to diagnostic evaluation by a qualified medical professional
- **OP-21:** ED median time to pain management for long bone fracture
- **OP-23:** ED head CT or MRI scan results for acute ischemic stroke who received heat CT or MRI scan interpretation within 45 minutes of arrival

The Plan

- Compare your performance to the national baseline median threshold for each OP measure
- Identify the measure or measures that have the greatest opportunity for improvement
- Why are the outcomes what they are?
- Determine how to measure the process, report the data, and demonstrate improvement on the identified measures

Project Progress

- Determine a way to measure the process and improvement
- Determine if the change has resulted in improvement
  - Construct up-to-date run charts
- Document multiple PDSA cycles
- How is the data being abstracted and reported?
  - Is it capturing the improvement?

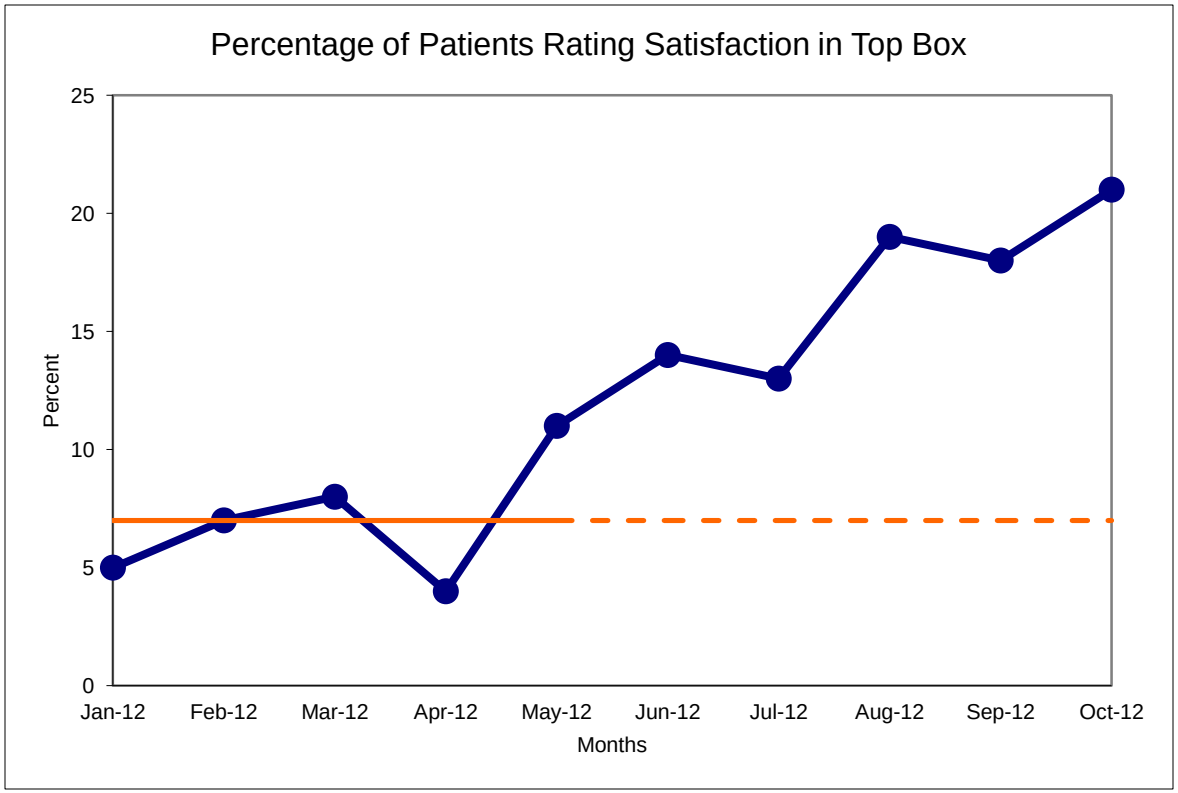
Understanding Variation

- **Statistical Process Control:** using statistical methods and visual display of data to understand common cause vs special cause variation
- Understanding variation allows us to make improvements to the process that will lead to better outcomes
  - Want to reduce the range of variation over time
  - PDSA the process toward desired improvement
- Most variation is due to the process design
- Common Cause or Random variation indicates a stable process
- Special Cause or Non-random variation indicates an unstable process

The Data

- You have performance data, now what do you do with it?
- **Run chart:** graphical representation of data plotted over time
- Method for communicating and understanding variation
- How will we know that change is an improvement?

Run Chart


Percentage of Patients Rating Satisfaction in Top Box
25
20
15
10
5
0
Percent
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Months

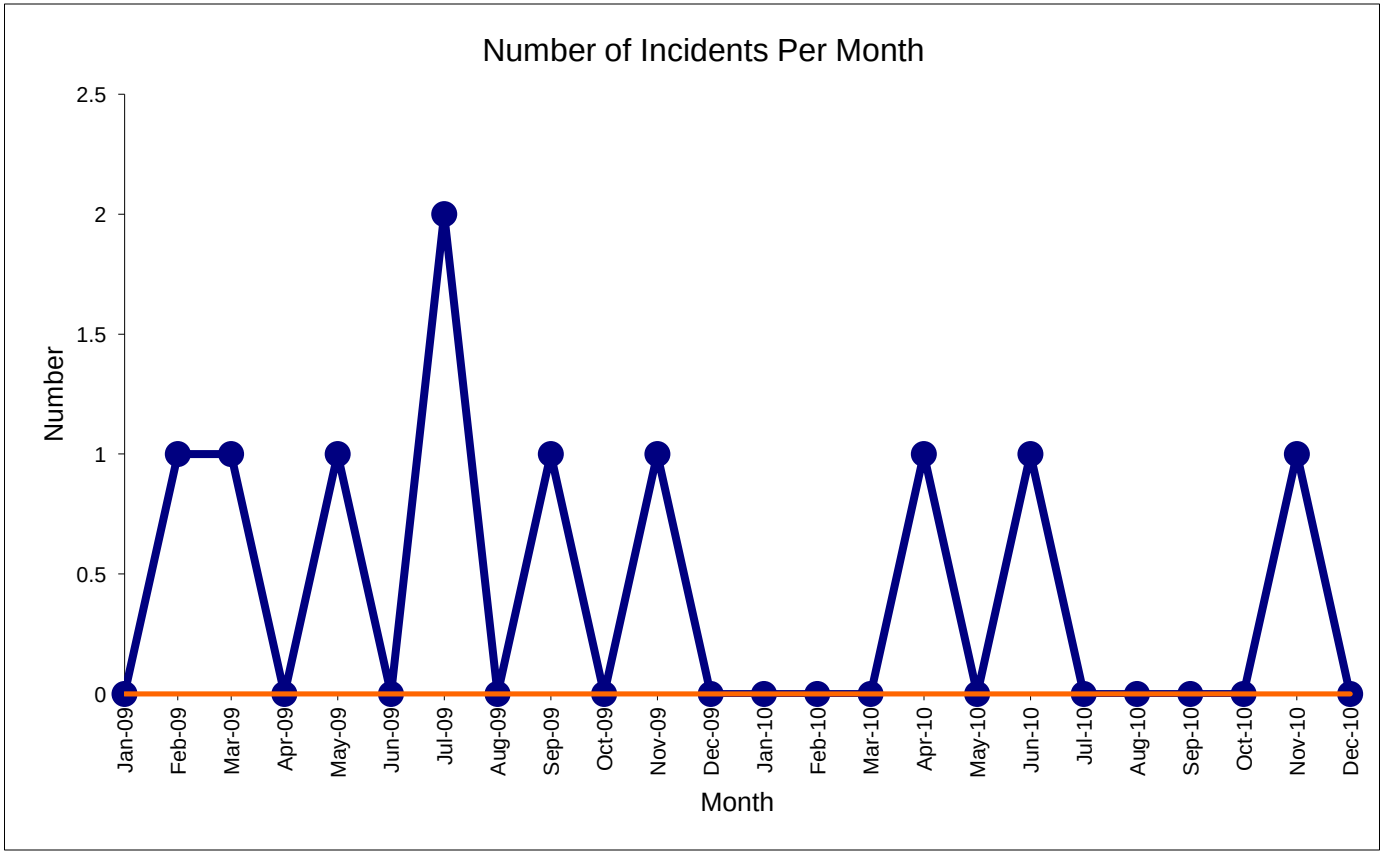
Significance

- Make practical significance readily apparent
- Detect nonrandom changes
- Prevents the overreaction of random variation
- Application in healthcare
  - Displaying data to make process performance visible
  - Determining whether a change resulted in improvement
  - Determining whether gains made through the improvement effort are being sustained

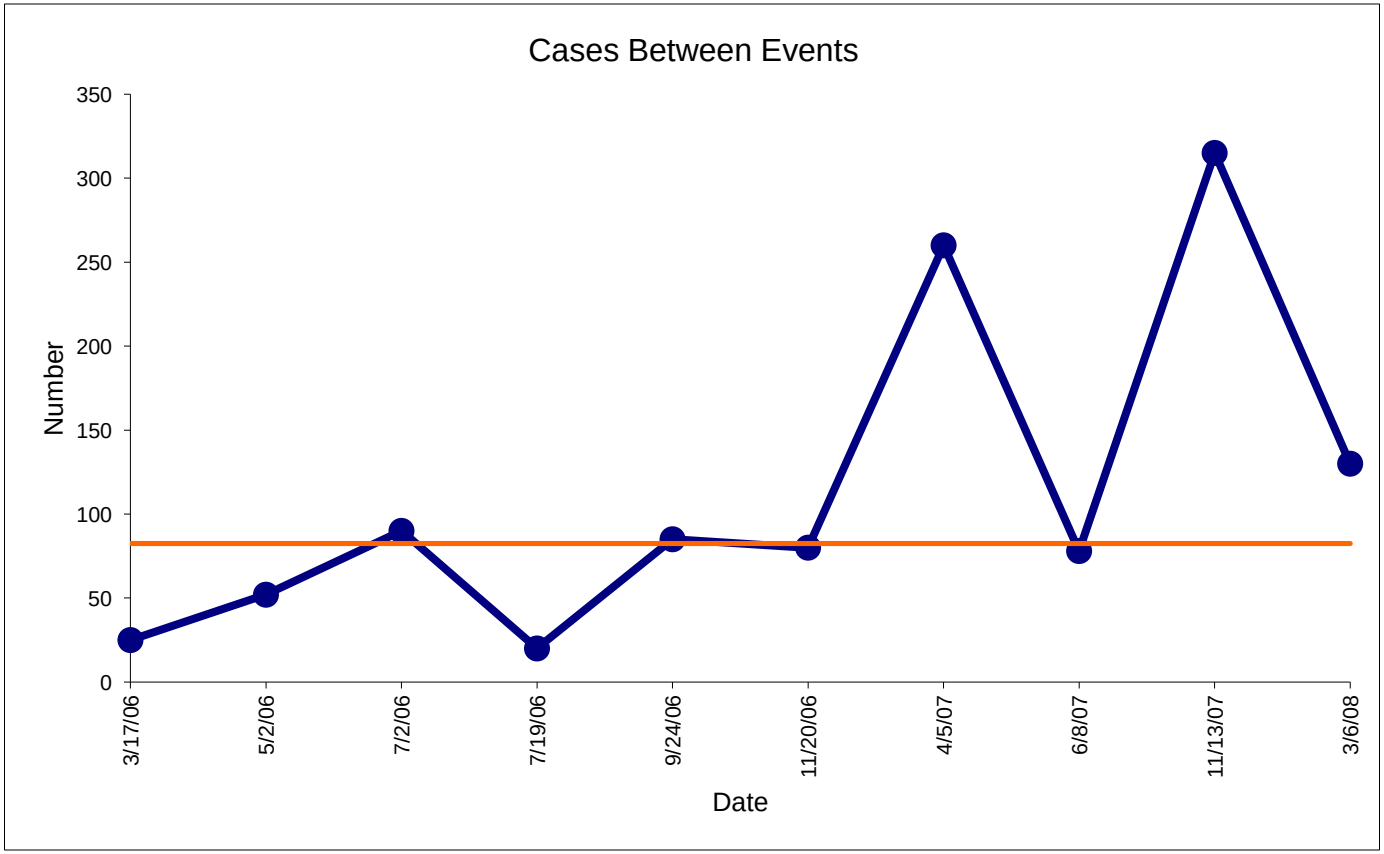
Plotting Rare Events Data

- Data that measures undesirable events that are relatively rare
- Too many zeroes can occur on the run chart
- Difficult to visualize improvement
- Run chart displaying time or workload between events is more effective
- More time or workload between events can indicate improvement

Too Many Zeros



Cases Between Events



When do I Start a Run Chart?

- When data for the first point to be plotted is available
  - Can learn from data as soon as possible
- More beneficial than using tables
- Can see effect of change in real time
- Probability-based rules can only be applied when there are 10 data points
  - Trends and astronomical points can be detected without needing 10 data points

Nonrandom Change?

- Any single rule occurring is sufficient evidence of a nonrandom signal of change
- The signal provides evidence for improvement if it is in the desired direction
- If the signal is in an undesirable direction, it means there is a negative consequence or factor influencing the measure

Bringing it Together

- Identify OP measures with opportunity for improvement
- Understand the current process
- Complete PIP
- Use run charts to track improvement
- Move toward the national baseline median threshold

Next Steps

- Send me an email or type into the chat box if you are interested in anything that I have discussed
  - Brady.Allen@area-d.hcqis.org
  - Have you already identified measures/areas to work on?
  - Are you currently working on improving any OP Measures?
  - Indicate which measure(s) you would be interested in receiving assistance on
- If you indicate interest, I will contact you with more information and a plan on where to go from here